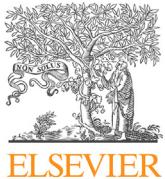




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Sláintecare implementation status in 2020: Limited progress with entitlement expansion[☆]

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ABSTRACT

The Sláintecare report developed by political consensus sets out a ten year plan for achieving Universal Health Care (UHC) in Ireland. This paper evaluates the design and progress of the report to mid 2020, but with some reflection on the new COVID 19 era, particularly as it relates to the expansion of entitlements to achieve UHC. The authors explore how close Sláintecare is to the UHC ideal. They also review the phased strategy of implementation in Sláintecare that utilises a systems-thinking approach with interlinkages between entitlements, funding, capacity and implementation. Finally the authors review the Sláintecare milestones against the reality of implementation since the publication of the report in 2017, cognisant of government policy and practice. Some of the initial assumptions around the context of Sláintecare were not realised and there has been limited progress made toward expanding entitlements, and certainly short of the original plan. Nevertheless there have been positive developments in that there is evidence that Government's Implementation Strategy and Action Plans are focussing on reforming a complex adaptive system rather than implementing a blueprint with such initiatives as integrated care pilots and citizen engagement. The authors find that this may help the system change but it risks losing some of the essential elements of entitlement expansion in favour of organisational change.

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1. Introduction

The Irish health care system is funded primarily through taxation (73 % in 2017), though this is below the EU average for solidarity funding. It is one of the more expensive health systems in the EU at €3406 per person [1]. Yet it does not provide free or even subsidised access to GPs for the majority of the population and this is unique in Western Europe [2]. Despite having a safety net system (through the provision of medical cards to those on low incomes to allow them free care) there is also a prescription item charge or levy specifically for those with low incomes [3]. Others pay full cost up to a monthly maximum amount. Furthermore, health care accessibility for public hospital inpatient treatment is particularly problematic with very long waiting lists and times. Consequently the system has a substantial voluntary private insurance sector, covering around 45 % of the population, the third largest in OECD after France and Slovenia [4]. Yet unlike in those countries this

insurance cover has historically allowed faster access into the public health care system, without full financial protection from user fees. Private insurance is also publicly subsidised [5] in that households can claim back tax on their private insurance spending, at the rate of 20 %, limited to the cost of the policy up to a maximum of €1000 per adult and €500 per child. Those who can afford private insurance have gained faster access to in-patient care producing a two-tier system for acute care.

There is no universal entitlement to public health care in Ireland, with eligibility varying according to residency, age and means [5]. The population is divided technically into two main eligibility categories [2]:

- Category I: those who qualify for medical cards (a third of the population). These are primarily allocated on the basis of income through a stringent means test that takes into account income, savings, investments and property (except the family home). The over 70 s have a much higher income threshold for a medical card. They get free access to GPs and other primary care (where available), heavily subsidised prescription drugs and free inpatient care.
- Category II: those without medical cards (two thirds of the population).

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Box 1: What are the main components of Sláintecare?
Sláintecare proposal are:

- Entitlement for all Irish residents to a broad package of health and social care
- Free access to GP, primary or hospital care and reduced charges for drugs
- Care provided at the lowest level of complexity, often outside of hospital, in an integrated way
- eHealth as key tool for developing a universal health system and integrated care
- Strong focus on public health and health promotion
- Waiting times guarantees with a maximum: 4 h wait time for Emergency Departments; 10 days for a diagnostics test; 10 weeks for an outpatient appointment; 12 weeks for an inpatient procedure.
- Private care phased out of public hospitals
- Significant expansion of access to diagnostics in the community
- Earlier and better access to mental health services
- An expanded workforce including allied health professionals, nurses and doctors. The importance of addressing recruitment and retention issues of all healthcare staff and the development of integrated workforce planning is emphasised in the report
- A new Health Service Executive Board, to be established promptly, to be the governing body of the Health Service Executive (HSE), accountable to the Minister for Health for the performance of its functions.
- Accountability and clinical governance, to be legislated for
- A National Health Fund set up to ring-fence funding for a transitional fund and expansion of entitlements.

Source: Centre for Health Policy and Management (2017)

Other key schemes provide additional benefits on the basis of age (GP visit cards which provide free GP care to the under 6s and over 70s) and health status (the Long-term Illness (LTI) Scheme which provides free drugs and appliances for those with certain chronic conditions). Anyone who is "ordinarily resident" in Ireland (living in Ireland and intending to live in Ireland for at least another year) can apply for a medical or GP card or other schemes.

Only since 2011 has Government endorsed universal health care as a viable strategy for government policy [6]. Recent analysis highlights that many households on low income may experience catastrophic or impoverishing health care expenditures despite having medical cards [2].

In an attempt to address key system failings the Sláintecare Report (2017)(7) was developed by an all-party parliamentary committee. It sets out a ten-year strategy to achieve UHC. The development and content of the policy have been highlighted in a previous article by the authors [8]. In short, Sláintecare promotes UHC by lowering financial barriers to access including phasing in free GP, primary and inpatient care. It removes private care from public hospitals and therefore removes faster access for the privately insured. It provides waiting time guarantees and invests in the system to deliver integrated care and improve accountability (see Box 1).

In this follow-on paper the authors evaluate:

- 1) How close Sláintecare is to the ideal of Universal Health Care
- 2) The systems thinking approach to transition in Sláintecare
- 3) How Sláintecare has evolved since its publication in May 2017 particularly in relation to the expansion of entitlements to care

Finally, the authors discuss the reasons for the distinctive nature of progress to date and why the original Sláintecare targets have been missed and to what extent this can and should be remedied.

1.1. Sláintecare and UHC

A key question is to what extent Sláintecare, when fully implemented, achieves UHC, the primary goal set out in its Terms of Reference [8]. UHC can be defined as timely, universal access to a full package of quality care without financial hardship [9]. Working out exactly what this entails is a challenge for any country. Key issues relate to whether care should be free or just affordable and how comprehensive a package of care needs to be. Furthermore, the quest for UHC may never fully be realised because of the potential for on-going improvement of health service provision and equitable access [10]. Consequently a key challenge facing any health system is where to focus scarce resources to move the system most towards achieving UHC [11]. While some analysts favour a minimal universal benefits package with additional pro-poor policies [12,13], many countries implement a larger UHC package without 100 % coverage across all the population [14].

The focus of Sláintecare is therefore dictated by context in its attempt to translate UHC into the Irish health system. Its aim is to redress some of the most gaping historical inequities and system failures in Ireland [7]. Hence it focuses in on removing all financial barriers to care for key parts of the system to improve financial protection across all the population, providing waiting time guarantees in line with best practice internationally so that access to care is timely and removing the ability of the privately insured to get faster access into public hospitals, promoting universality.

The main features of Sláintecare are highlighted in Box 1.

https://www.tcd.ie/medicine/health_policy_management/assets/pdfs/policy-brief-on-the-slaintecare-report-19122017.pdf

In this regard Sláintecare, if fully implemented as envisaged in 2017, makes huge strides from the current state of the Irish health system, as discussed in the introduction. The strengths and weaknesses of the design are noted below:

1.2. Strengths

- It removes all access charges for those currently paying for GP care (around 58 % of the population in 2017), all access charges for a range of primary care services and all access charges to hospital inpatient care and Emergency Departments for those currently paying directly (around 23 % in 2017) [5]. (Note: Hospital inpatient charges or fees are only levied on those who do not have medical cards or those who do not present with private insurance and are capped at 800 euro annually.)
- It establishes waiting time guarantees, in line with international standards [15] for different types of care with remedial options where they are breached. Waiting time guarantees have proved helpful in addition to strategies that improve supply side capacity, e.g. England, Finland and the Netherlands [16]. They help ensure timely access to care and facilitate accountability.
- It sets out the removal of private care from public hospitals. Hence all rooms in public hospitals will be public rooms available to public patients. There will be a common waiting list and no way to jump the queue through additional payments. Those with private insurance are no longer allowed to get faster access into rooms in public hospitals. This removes two tier access to public care so that financial barriers no longer inhibit access to care in public hospitals (17).
- It establishes a legal entitlement to free care and not an eligibility based on individual characteristics (such as age, means or residency). This improves accountability in the system through a rights-based approach. By allowing patients to have a legal

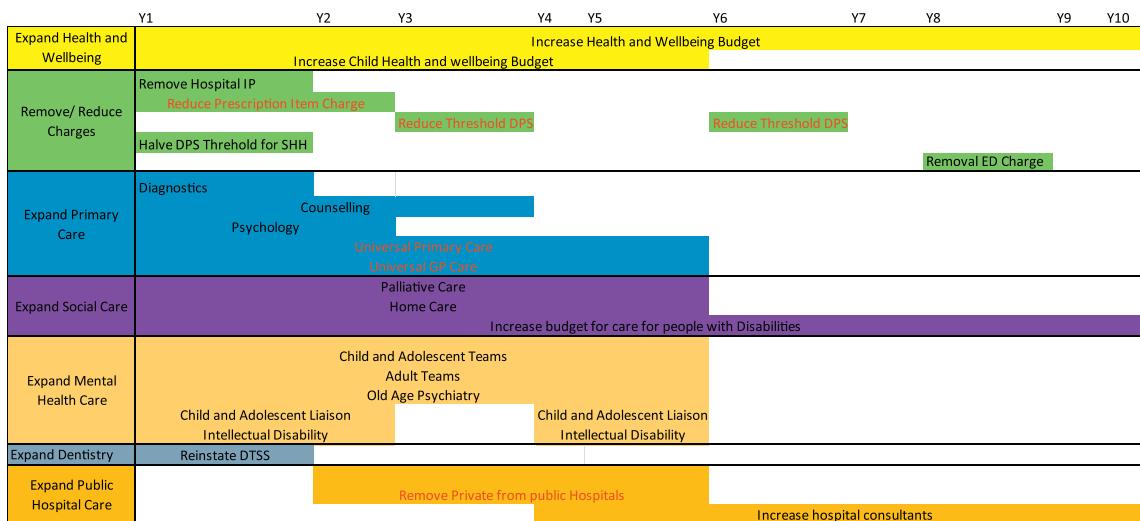


Fig. 1. Original Sláintecare report phased implementation over ten years.

Note: Items in red are high cost items. Y1 is Year 1 of implementation etc, originally intended to be 2018. DPS is Drug Payment Scheme (A Reimbursement Scheme for Households spending more than a threshold amount per month). ED is Emergency Department. DTSS is Dental Treatment Services Scheme.
Source: Derived from Houses of the Oireachtas (2017)

entitlement rather than just an eligibility it provides a basis for appeal, challenge or corrective action should this entitlement not be realised [18]. This then permits focus on those responsible for non-delivery and making good of the legal entitlement to deliver universal care.

1.3. UHC weaknesses

- It does not remove all charges associated with prescriptions. In particular prescription item charges for the poorest section of the population remain in place (albeit significantly lowered to €0.5 per item)
- Relatedly it only reduces drug reimbursement thresholds to €100 per family per month, which may still cause financial hardship for those paying up to the limit and is a long way from free prescription drugs. (Drug reimbursement thresholds relate to the maximum amount that a household may spend on prescription drugs before the state covers further expenditure.)
- While making a commitment to a universal package of dental care, in the costings and implementation it only refers to a minimal dentistry package and only reinstates what previously had been in place for those with medical cards, which was limited.
- There is a greater focus on removing all user charges for specific types of care rather than the financial protection of households, and limited emphasis on a wide package of benefits, including implementation of universal access to homecare packages or home help. Whilst these services are included in the Sláintecare broad basket with targeted funds, there are no specific targets for achieving universal access.

Hence Sláintecare while providing political consensus and a costed plan and strategy to achieve a single tier system in some instances falls short of the ideal of UHC, which all plans will do to some extent.

This is partly because of a historic value set in Ireland, with beliefs that people ought to pay something for their care or drugs [19,20]. It is also because the committee chose to target free care for some high-profile items, such as GP care, over other package elements. In general, the decision-making processes on the committee were based on consensus where possible, only occasionally resorting to a simple vote. Some political difference did have a role

in relation to some policies such as the partial removal of the prescription charge, and other areas of policy which did not feature in the report such as the private hospital sector or the government subsidy of private health insurance.

It is also partly because of financial affordability and the very high cost of lowering drug reimbursement thresholds below €100 per month. Nevertheless, much is proposed in the Sláintecare report to radically advance the Irish healthcare system substantially towards UHC.

2. Systems thinking in reform implementation

While having a vision of a reformed system is important, understanding the stages and phases to get there is critical and often overlooked. Health system reform needs to take into account the interacting nature of the functions or building blocks of a health system [21] as it seeks to plan a transition to a reformed system. Improving access, quality and financial protection cannot be done independently of other health system factors such as finance, human resources and information systems [22]. Accordingly, Sláintecare to its credit endorses a phased approach to achieve a single tier, universal system by a gradual expansion of entitlements over ten years with associated system change, as highlighted in Fig. 1.

Furthermore, there are several strategies identifiable from the report and the workings of the committee which are useful to identify to provide learning for system transition.

2.1. Quick wins

The credibility of Sláintecare with the public and key stakeholders may well revolve around how quickly it delivers change. There are a number of headline changes in the first few years of the plan which involve reducing access costs without any additional burden to the system (e.g. reducing the prescription item levy, lowering the prescribed drug payment reimbursement threshold for single headed households).

2.2. Phasing of entitlements with expansion of system capacity

Several of the most costly and biggest impact items, such as universalising GP and primary care access and removing private

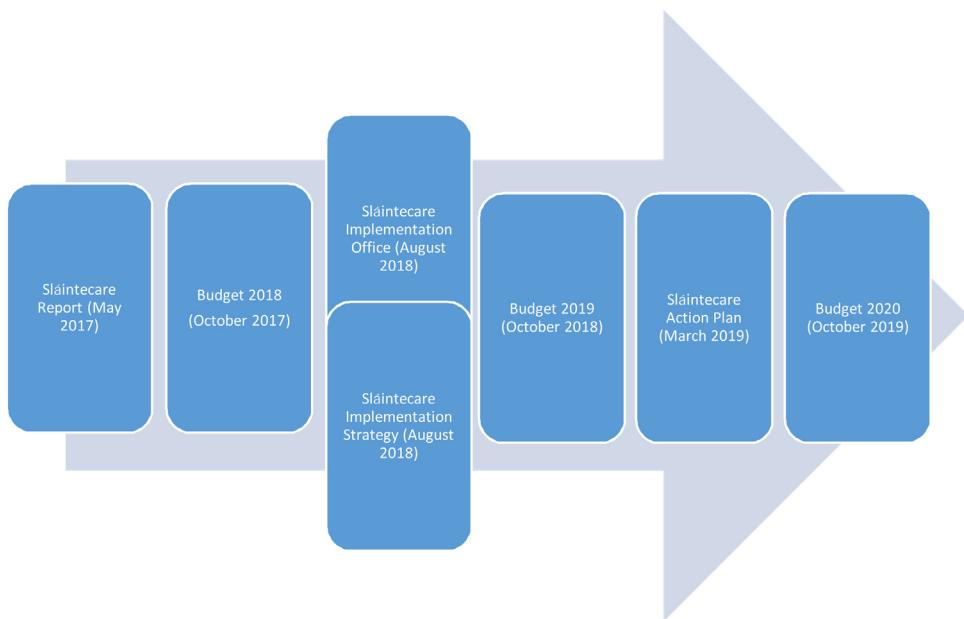


Fig. 2. Policy Timelines: Sláintecare Strategy Evolution 2017-2019.

care from public hospitals, will take several years to implement. Such phasing allows system capacity to expand and the requisite finances to be in place.

Three candidate parameters were considered for such phasing: age, need and means. It was deemed impossible to phase on the basis of need given its shifting nature [6]. Instead the extension of free access to GP care was done on the basis of means – by raising the income thresholds for GP visit cards (allow free access to GPs but no further benefits). Nevertheless there was also some targeting by age in terms of improving child health and wellbeing services.

2.3. Ensure system integrity

Once multiple entitlements are being phased-in with lowering of cost barriers there comes the risk of perverse incentives should things be done in the wrong order and patients seeking care at the wrong access point. This is avoided by careful sequencing. For instance the removal of charges for Emergency Departments (EDs) is delayed to Year 8 to avoid further bottlenecks here.

2.4. Financial affordability for government

A fundamental issue for Government is the affordability of Sláintecare on top of other cost pressures such as the rising burden of chronic diseases and new medical technologies. The maximum needed in any one year for specific Sláintecare entitlement expansion and recurrent costs is €463 million in Year 3. Some of this is burden shifting from households to government through the decrease or removal of co-payments and fees and therefore could be compensated by increased revenue-raising measures (e.g. higher income tax or increase pay-related social insurance.)

2.5. Establishment of a transition fund

This fund helps build up the health system capacity to cope both with the expansion of entitlements and the move to providing care outside of hospitals. It deals with expanding physical infrastructure, training additional primary and social care human resources and upgrading the IT capacity. Several other countries have used or proposed transition funds to accomplish reform [23].

While this careful transition planning provides a useful blueprint for reform it perhaps does not take into account the complexity of the health system and how the system might dynamically respond to policy change [24].

3. Sláintecare evolution

Given the complexity and ambition of the Sláintecare reform programme it is interesting to see how it has been implemented. The Sláintecare Report was published in May 2017 with an expectation that an implementation office would be established over the summer of 2017 and that funding for the first year of the plan would be incorporated into the October Budget for 2018 and then implemented thereafter [7]. Year 1 of implementation was initially envisaged to be 2018.

The Sláintecare Report was originally a political cross-party policy and not a formal government policy. This may explain why it was only in August 2018, fifteen months after the original report, that it became official government policy with the Sláintecare Implementation Strategy [25] and the establishment of the Sláintecare Implementation Office. A further nine months were needed before the Sláintecare Action Plan 2019 [26] was published with particular phased targets and strategies. In addition there have been three budgets since publication of the Sláintecare Report. The policy timelines for Sláintecare implementation are shown in Fig. 2.

Over the two and a half years and the various Government publications the policy has evolved as it has been adopted, resourced and partially implemented by government. This is shown in Table 1 (at end), which compares the entitlements specifics of Sláintecare with what was introduced in the Budget 2018, the Sláintecare Implementation Strategy, Budget 2019, the Sláintecare Action Plan 2019 and Budget 2020.

What is apparent is that the policy, phasing and timelines have changed as Government has taken up Sláintecare. There has been substantial innovation in terms of a Sláintecare Integration Fund to resource pilots around integrated care, a new GP Contract and plans for citizen engagement and removing private care from public hospitals through the de Buitleir report [17]. These all provide a foundation for reform. Nevertheless, the pursuit of lowering access costs to care and entitlements seems to have taken a back seat to

Table 1
Evolution of Sláintecare and Entitlement Expansion (May 2017–December 2019).

	Sláintecare Report (May 2017)	Budget 2018 (October 2017)	Sláintecare Implementation Strategy (August 2018)	Budget 2019 (October 2018)	Sláintecare Action Plan (April 2019)	Budget 2020 (October 2019)
Principles	Achieve UHC over ten years. Modern, accountable, integrated and patient-orientated system.	General Endorsement of Sláintecare but some repackaging of other activities under this banner	Endorsement of Sláintecare values and reform programme and yet eligibility is used instead of entitlement all except once in the report	Endorsement of Sláintecare with specific funding package		Endorsement of Sláintecare with focus on capacity
Strategies	Phased expansion of capacity and entitlements	Provision is made for costs associated with development of a GP contract, expansion of Community Intervention Teams, additional Occupational Therapy posts and the extension of the GP Out of Hours.	A system-wide programme of reform. A Sláintecare Integration Fund to drive improvements in delivery. Focus on integrated care, alignment of geographies and pooled resource allocation and transition fund. No expanded HR capacity.	New €20 m Sláintecare Integration Fund to drive improvements in the delivery of care. Recruitment of additional front line staff, including consultants and development of a new GP contract.	Comprehensive approach to complex system reform. Focus on workforce and integrated workforce planning. Focus on new model of service delivery and regional integrated care organisations and improving waiting list data.	Expansion of front-line workforce and home-help support.
Entitlement expansion	Years 1 and 2: Removal of IP fees for public hospitals. Halving of Drug Payment Scheme Thresholds for single headed households. 400,000 more with free GP care. Reinstatement of dental benefits for people with medical cards. Reduction of prescription item charge to €0.5 per item	Prescription charges for medical card holders under 70 years of age are reduced to €2 per item (from €2.5 per item), up to a maximum of €20 in any month, in line with the reduction applied to over 70 s in Budget 2017. The monthly threshold of €144 for clients of the Drug Payment Scheme is reduced to €134. Additional funding to the NTPF bringing to €55 m the investment in the NTPF for initiatives targeted at those waiting longest. Additional money for mental health and community staffing.	No specifics on entitlement expansion and funding	Reducing prescription charges for persons over 70 years of age by 50%. Reducing the monthly threshold for the Drug Payment Scheme by €10. Increasing GP visit card income thresholds by €25. Additional investment of €20 m in the National Treatment Purchase Fund (NTPF) to reduce waiting lists. Additional money for mental health and community staffing.	Very little on funding to back up entitlements. Seems to propose rethinking how to do it.	Reduction of 50c in prescription charges from July. Expansion of free GP care to children under 8 and free dental care for under 6 s from September. The monthly threshold of €124 for the Drug Payment Scheme will be reduced by €10 to €114 from September. Increased income limits for medical cards for over 70 s. €100 million for the National Treatment Purchase Fund (NTPF) to help reduce waiting lists

other areas of work (on the new regions and their capacity). In the Government's Implementation Strategy there is only one mention of expanding entitlements and across the Implementation Strategy and Action Plan there is no detail on how or when to lower access costs.

It might be claimed that the lack of progress towards extending entitlements is just a reality of the circumstances of Sláintecare's origin and translation for policy makers in the Irish healthcare system. The original report focussed on design but not the political realities of getting all stakeholders on board [27]. In contrast, the Implementation Strategy and particularly the 2019 Action Plan are more focussed on collaborative stakeholder engagement and system reform. It could be argued that such strategies are more suited to the realities of a complex adaptive system [28] and perhaps move away from a blueprint approach [29] to one that is more collaborative. Further meeting the funding requirements of Sláintecare was always going to be challenging given the frequent overspending in

the annual healthcare budget [30] and other demands and needs outside of Sláintecare, such as the new children's hospital [31].

Nevertheless, the very limited progress with entitlement expansion by the end of 2019 must be of concern. Even those strategies set out in the original report that represent quick wins (small cost, totemic value and no system burden) are unaddressed in subsequent policy documents and discourse. Indeed, the specifics of entitlement expansion and even the general principle of lowering costs of access/removing charges seem to have been pushed back. Instead, organisational reform and integrated care have received more focus. Nevertheless, unless entitlements are in operation then appropriate pathways to integrated care may be blocked by access charges at the wrong point in the system.

A further question is whether there is a government tendency to embrace organisational reform. The prioritisation of system reorganisation is a historic default trend for the Irish health care system, most recently with the abolition of the Health Boards, replaced by

the HSE, in 2005, the formation of Hospital Groups in 2013 and of Community Health Organizations in 2015.

It was hoped that the 2020 election might signal a positive shift for Sláintecare. The rejection of the historic major parties because of frustration at the state of the health and housing sectors gave a wake-up call to the political establishment in Ireland [32], although it did not produce a clear majority government. Furthermore, the onset of COVID-19 initially saw a renewed focus on the health system and the caretaker government moved substantially towards a single tier system. From mid-March, there was universal access to remote GP care through telemedicine for those presenting with COVID-19. From 1st April, the public sector contracted with private hospitals to deliver free care to all for the duration of the COVID-19 crisis [33]. Nevertheless, such movements towards universal care are being unwound and it seems unlikely that the response to COVID-19 will immediately facilitate Sláintecare. The commitment to entitlements still seems to be elusive [34].

4. Discussion and conclusions

Sláintecare is an ambitious and complex programme of reform aiming to achieve UHC in Ireland over a decade. It provides a vision of a changed system and a blueprint for reform implementation. While it does not universalise all aspects of care, it expands the package of care available, removes the two-tier access to public acute care and frees up GP, primary and inpatient services. However, its scope may have created problems for implementation and while government has endorsed it in general it appears to be focussing the policy on integrated care. The risk is that the emphasis on entitlements to free care may be lost in the process and may need fresh political energy.

Key lessons for policy makers are:

- Drift in policy focus will always be challenge for any large-scale and long term reform. Systems may tend toward historic tendencies and patterns and political support for reform may ebb unless attended to. Hence every opportunity must be taken by reform managers to re-establish and consolidate stakeholder support and consensus for the fundamental principle and values of the reform through implementation.
- The pace of change of reform transition needs to be realistic but will be facilitated by (i) earmarking finances for enabling both entitlement expansion and system transition, and (ii) linking organisational reform and capacity building to entitlements expansion to ensure effective system change
- Initial and detailed reform blueprints must evolve to incorporate system complexity while not losing the focus of reform vision.

RediT authorship contribution statement

Steve Thomas: Conceptualization, Writing - review & editing. **Bridget Johnston:** Writing - review & editing, Formal analysis. **Sarah Barry:** Writing - review & editing, Formal analysis. **Rikke Siersbaek:** Writing - review & editing, Data curation. **Sara Burke:** Writing - review & editing, Investigation, Formal analysis.

Declaration of Competing Interest

The authors were involved in the development of the original Sláintecare report published in May 2017, providing technical support to the Oireachtas Committee on the Future of Healthcare. They have no other conflicts of interest.

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